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Rhode Island Board of Medical Licensure and Discipline

Room 205 Three Capitol Hill Providence, RI 02908-5097

Instructions and Application For

License to Practice

Allopathic Medicine ☐ Osteopathic Medicine ☐
Applicant - Print Name (First/MI/Last)

Phone: (401) 222-3855 TTY/TDD: (800) 745-5555 Fax: (401) 222-2158

I am also applying for a RI Uniform Controlled Substances Registration (CSR)

and have attached the CSR application to the last page of this application.

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Application Process Overview	Page 3
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Application Materials	
Board Application Voluntary Race/Ethnicity Questions ABMS Code Table Application Checklist Reciprocity Release Form Reference Form Rhode Island Uniform Controlled Substances Act Registration (CSR)	18

Licensure Requirements

U.S./Canadian Graduates

- Graduated from a medical school accredited by the Liaison Committee for Medical Education (LCME).
- Satisfactorily completed two (2) years of internship or residency by the Accreditation Council for Graduate Medical Education, Accreditation Committee of the Federation of the Medical Licensing Authority of Canada or the Royal College of Physicians and Surgeons of Canada.
- Satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Foreign Graduates

- Successfully completed a course of study from a medical school located outside the United States which
 is recognized by the World Health Organization.
- Obtained ECFMG certification.
- Have attained a score satisfactory to a medical school approved by the Liaison Committee on Medical Education on a qualifying examination acceptable to the State Board for Medicine.
- Have satisfactorily completed three (3) years of internship or residency in a training program accredited by the Accreditation Council for Graduate Medical Education.
- Have satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Rules and Regulations

The rules and regulations governing the Practice of Medicine can be obtained at the following web site:

http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD_2961.pdf

Rhode Island General Laws pertaining to the Practice of Medicine can be obtained at the following web sites:

Medical Licensure http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm
Controlled Substances Act http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted jointly by the Rhode Island Board of Medical Licensure and Discipline (Board) and the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). All licensure applicants must complete and submit a Board application **and** a separate FCVS application.

FCVS Application Process

To have your "core" credentials verified, you must submit an FCVS application directly to the Federation's national office (Texas). This application must be obtained by contacting the Federation toll free at **1-888-ASK-FCVS** (1-888-275-3287), or it can be downloaded at the Federation's web site at:

http://www.fsmb.org

This verification process is conducted separately and independently by the FCVS in accordance with established policies and procedures set forth by the Board. Because the verification process is the most time-consuming task, it is recommended that you submit this application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application.**

The FCVS will verify your applicable credentials from the original, primary source in the following categories (some may not apply):

- Medical Education (including Fifth Pathway)
- Postgraduate Training
- Examination History
- Board Action History
- ECFMG Certification
- Identity

When all information is received and reviewed for accuracy, FCVS will forward directly to the Board, a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials. For more information about the FCVS process, or if you need assistance completing the FCVS application, call the Federation toll free at **1-888-ASK-FCVS** (1-888-275-3287).

Board Application Process

In addition to the FCVS application and verification process, you must submit additional information directly to the Board. The Board will use this information, along with the FCVS Profile, to assess your qualifications for licensure. Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets during the first week of each month. Only applications which are complete, including all outside verifications, will be forwarded to the Board for review and issuance of a license. So that we can move the process along more quickly, if you are an endorsement candidate, and hold an active, unencumbered license in another state, your applications materials will be presented to the Board and a license may be issued **prior** to our receiving the FCVS application. If we thereafter identify any problems with your FCVS application, your license will be voided. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. You are responsible for notifying the Board office, in writing, if your address changes in the interim.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact Lauren Dixon at (401) 222-7887, or by email at LaurenD@doh.state.ri.us.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions

- 1. Make a copy of the application and forms before you begin, in case you make a mistake.
- 2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.
- 3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
- 4. We suggest that you make a copy of your completed application before submitting it to the Board.
- 5. It is your responsibility to check on the status of your application.

Completing your Board Application

- 1. Complete the **Board Application** pages (6-12). You must respond to <u>all</u> components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages MUST clearly indicate the section for which such information is being reported.
- 2. Make a check or money order (in U.S. Funds only) for the application fee of \$437.50 (or \$537.50 if you are applying
 for your Controlled Substances Registration (CSR)), payable to "Rhode Island General Treasurer" and staple it to
 the upper left-hand corner of the first page of the application. These application fees are NON-REFUNDABLE. If
 you are applying for your CSR, you MUST submit the Board application at the SAME TIME as the CSR application.

 NOTE: These are Board Application Fees. The FCVS verification fee is an additional and separate fee paid directly
 to the FCVS.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (see page 16). Do not submit applications without all applicable information, documentation and fee. Mail these components of the application to:

Rhode Island Department of Health Board of Medical Licensure & Discipline Room 205, Three Capitol Hill Providence, RI 02908-5097

Physician-Initiated Requests

In addition to the materials you mail to the Board, you must also mail information to other sources for verification. Follow these additional steps as described below:

- 1. Obtain licensure verification from all states where you hold, or have ever held, a license to practice medicine. To obtain this verification, you must mail the **Reciprocity Release Form** (page 17) to <u>each</u> licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.
- 2. Be certain to sign and complete the identifying information on each form. The Board must receive the verification(s) directly from the licensing authority. Make copies of the form as needed. You may obtain

INSTRUCTIONS (continued)

the mailing address of all 69 U.S. medical and osteopathic licensing authorities at the Federation of State Medical Boards' web site at http://www.fsmb.org or by calling the Board in question. Please do not contact the Rhode Island Medical Board for mailing addresses of licensing authorities.

3. Submit a "self-query" of the National Practitioner Data Bank (NPDB). The application is a **Practitioner Request for Information Disclosure**, which can be obtained by calling the NPDB, or downloading it from the NPDB web site.

Phone Number for NPDB Information: 1-800-767-6732

NPDB web site: http://www.npdb-hipdb.com

You must mail this completed form directly to NPDB. When you receive a response, send the Board the ORIGINAL, UNOPENED response. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible.

- 4. Obtain a total of four *(4) references* attesting to your character and professional abilities. To obtain this verification, mail the enclosed **Reference Form** to each the following:
 - Chief of Staff in the hospital where you currently hold staff privileges;
 - · Hospital Administrator in the hospital where you currently hold staff privileges;
 - Two (2) additional practicing physicians.

If you **do not** currently hold staff privileges, mail the **Reference Form** (page 18) to each the following:

- · Chairman of the department where you had your major training;
- · Director of Residency or Fellowship Training Program;
- Two (2) additional practicing physicians.

Letters or other forms submitted in lieu of the Reference Form will not be accepted. *The Board must receive these forms directly from the reference source.* Make copies of the form as needed.

- 5. Submit a notarized copy of your American Board of Medical Specialty Certificate(s), if applicable.
- 6. In order to dispense, prescribe, store, or order controlled substances, you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.

 The Rhode Island CSR Application is available on page 19. After you obtain your Rhode Island CSR you can apply for

a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA:

DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

The application process is not considered complete until your Board application, applicable forms and FCVS Physician Information Profile are received in a manner satisfactory to the Board. Neither the Board nor FCVS will accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed and you will be contacted in writing. Be advised that you may be required to appear for an interview. Please allow 7-10 working days following the Board meeting for your wallet size license card to be mailed to you. [NOTE: You may **not** practice medicine in Rhode Island until you have received a license number.]

Special Notice about Malpractice Information

In Section 17, "Malpractice":

Pursuant to R.I.G.L. § 5-37-9.2, the Rhode Island Board of Medical Licensure and Discipline must collect data regarding your malpractice history. You are required to report to the Board all actual settlement or jury verdict amounts in the past 10 years. The Board will **not** make actual settlement or verdict amounts available to the public. It must report the fact that a payment was made and how it compared to other payments made in your specialty. For each incident you report, you must include documentation that verifies the date, place, reason and disposition of the matter.



State of Rhode Island Board of Medical Licensure and Discipline

Application for License to Practice Allopathic Medicine

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens. 1. Name(s) This is the name that will be printed on your license and reported to those who inquire about First Name your license. Do not use nicknames, etc. Middle Name Surname, (Last Name) Suffix (i.e., Jr., Sr., II, III) Degree (MD, DO) Maiden, if applicable Name(s) under which originally licensed in another state, if different from above (First, Middle, Last). 2. Social Security Please refer to "Mandatory Addendum to License Application" Number on the last page of this application U.S. Social Security Number 3. Gender Female Male 4. Date and Place 1 9 of Birth Day Month City and State; OR Province and Country, etc., if NOT U.S. 5. Home 1st Line Address (Apartment/Suite/Room Number, etc.) **Address** It is your responsibility to notify the board of Second Line Address (Number and Street) all address changes, Zip Code Country, If NOT U.S. Postal Code, If NOT U.S. Home Phone Email Address (Format for email address is Username@domain e.g. applicant@isp.com) 6. Business **Address** Name of Business/Work Location It is your responsibility to notify the board of all address changes. 1st Line Address (Department/Suite/Room Number, etc.) This address will State appear on the Second Line Address (Number and Street) Zip Code Department of Health web site. City Postal Code, If NOT U.S. Country, If NOT U.S Business Phone **Business Fax**

	Applicant: Print your complete last name>
7. Preferred Mailing Address Please check ONE	Please use my Home Address as my preferred mailing address Please use my Business Address as my preferred mailing address
8. Speciality of Practice See ABMS Specialty Code list (page 15). DOCUMENTATION: You must provide a notarized copy of your ABMS certificate(s).	Board Certified?:
9. Practice Information A. Specify where in this State you intend to practice, and list type of practice. ACD = Academia ADM = Administration FTY = Facility FEL = Fellowship GRP = Group HSP = Hospital HMO = HMO OFC = Office RES = Research OTH = Other If necessary, continue on a separate 8½ x 11	Location#1 City Practice Type (See Codes) Location#2 City Practice Type (See Codes) Location#3
sheet of paper. B. Identify any translation services that may be available at your primary practice location.	City Practice Type (See Codes)
10. Practice History 10A. Training History Account for each year of training activity from the present. Explain gaps on separate Account for each year of paper. 10B. Work History Account for each year of work activity from medical school through the present. Explain gaps on separate saps on separate gaps on separate paper.	Month Year Month Year Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper. Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper. Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper. Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper.
10C. MedicalSchool Faculty Appointments Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent (10) years.	

		Applicant: Print your complete last name>
11.	Medical	State/Country: State/Country:
	Licensure	Active Inactive Active Inactive
	List all states or countries in which	Active Inactive Active Inactive
	you are now, or ever have been licensed	——————————————————————————————————————
	to practice medicine or any other	Active Inactive Active Inactive
	profession.	Active Inactive Active Inactive
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		Active Inactive Active Inactive Inactive
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		DOCUMENTATION: Send a Reciprocity Release Form to each entity. (See page 17)
	Board Discipline List any final disciplinary actions by licensing boards in other states. If necessary, you may continue on a separate 8½ x 11 sheet of paper. Check here if not applicable. Hospital Privileges List the name and address of all hospitals where you have ever held any type of privileges (e.g., courtesy, admitting, etc.). NOTE: This section is continued on the next page.	Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct): Month Year Type of Discipline: Type of Discipline: Type of Discipline: Type of Discipline: Type of Privileges Name of Hospital City State ZipiPostal Code Name of Hospital City State ZipiPostal Code Type of Privileges
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		Month Year Month Year Type of Privileges
		Name of Hospital

Applicant: Print your complete last name> 13. Hospital **Privileges** Month Year Month Year Type of Privileges Continued from previous page. Name of Hospital If necessary, you may continue on a Zip/Postal Code City State separate 81/2 x 11 sheet of paper. Type of Privileges Month Year Month Year Name of Hospital Zip/Postal Code City Type of Privileges Name of Hospital Zip/Postal Code City State Type of Privileges Month Year Month Year Name of Hospital Zip/Postal Code City 14. Hospital **Discipline** Month Day Year Type of Action List any revocation of hospital privileges for reasons related to Name of Hospital competence or quality of patient care that have been taken by the hospital's governing body or any other official of Month Dav Year Type of Action the hospital after procedural due Name of Hospital process has been afforded. Also report resignation from or the nonrenewal of medical Type of Action Month Day Year staff privileges or the restriction of privileges at a hospital Name of Hospital during the course of an investigation. Type of Action Month Day Check here if not applicable. Name of Hospital

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Applicant: Print your complete last name>

15.	Malpractice	_			_		_												
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Applicant: Print your complete last name>

18. Physician Honors and Peer	Awards, Honors:	
Reviewed Publications (Optional)		
List any information regarding professional		
or community service awards and/or information regarding		
publications in peer- reviewed medical literature within the most recent 10 years.		
Do NOT submit your curriculum vitae to satisfy the requirements of this		
section. If necessary, you	Publications:	
may continue on a separate 8½ x 11 sheet of paper.		
19. Professional and	Professional and Community Memberships:	
Community Memberships (Optional)		
List any professional and community		
memberships. Do NOT submit your		
curriculum vitae to satisfy the requirements of this		
section. If necessary, you		
may continue on a separate 8½ x 11 sheet of paper.		

Applicant: Print your complete last name:

20. Affidavit of Applicant

Complete this section and sign in the presence of a notary public. Make sure that you and the notary public have completed all components accurately and completely.

l	, being fir	st dulv	sworn.	depose	and	sav	that	I am	the
person referred to in the foregoing application a	-	_		-		,			

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentality's (local, state, federal or foreign) to release to the Rhode Island Board of Medical Licensure and Discipline any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/ surgery in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Medical Licensure and Discipline of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant	Date of Signa	ature (MM/DD/YY)
The foregoing instrument w	as acknowledged before me this	day of
, 20_	, by	,
who is personally known to	o me or has produced	
as documentation and did/d	id not take an oath.	
		:
Name of Notary (Print, Type or Stamp)	Signature of Notary	
		:

Commission Expiration Date (MM/DD/YY)

21. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone). Notary No/Commission No.

Photographs must be recent, passport photo, clear, front view, full face without a hat or dark glasses.

Full length photos, black and white or computer-generated photos will not be accepted.



Affix Photo Here

Sign your name on the line provided, partly upon the page and partly upon the photograph, and provide the date it was taken.



State of Rhode Island and Providence Plantations Department of Health

Office of the Director

Message from the Director of Health

Dear Applicant:

The following page contains questions regarding your race and ethnicity. The Department of Health is attempting to promote diversity among health professionals. The Department can measure its success in promoting diversity by identifying gaps in our diversity. Also, it will utilize this information in order to select members for professional regulatory boards at the Department of Health.

Answering these questions is entirely voluntary. Your willingness to provide this information will not affect your licensure in any way. Data will be used only in accordance with Title VI of the Civil Rights Act of 1964.

Rhode Island has a strong interest in promoting diversity among the health professions. Offering culturally competent health care, better serving minority communities, providing role models for minority youth and encouraging minority persons to become health professionals will make our communities healthier and safer.

Please join us in our attempts to attain these worthy goals by answering the questions on the following page.

Sincerely,

Patricia A. Nolan, MD, MPH Director of Health



VOLUNTARY RACE/ETHNICITY QUESTIONS*

This information is completely <u>voluntary</u> and will <u>NOT</u> affect your Application in any way.

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.								
1. Ethnicity: Are you of Hispanic or Latino ethnicity? Yes No								
2. Race: Please indicate your race below. (Check as many boxes that apply)								
American Indian or Alaska Native Black or African American White								
Asian Native Hawaiian or other Pacific Other (Specify Below) Islander								
Please specify Race, if you answered								
"other" above								
For the purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:								
<u>Hispanic or Latino</u>								
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."								
American Indian or Alaskan Native.								
A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.								
Asian (new group does not include Pacific Islanders).								
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan , Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.								
Black or African American.								
A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American".								
Native Hawaiian or Other Pacific Islander.								
A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.								
<u>White</u>								

ing Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.

*This information is being collected in accordance with the Department of Health's Policy for Maintaining, Collecting and Present-

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

AMERICAN BOARD OF MEDICAL SPECIALITY (ABMS) CODE TABLE

4& I	Allergy and Immunology	CL1	Clinical and Laboratory Immunology			FP	Forensic Pathology
	<i></i>	DL1	Diagnostic Laboratory Immunology			Hem	Hematology
						IP	Immunopathology
Anes	Anesthesiology	CCM	Critical Care Medicine			MMB	Medical Microbiology
		PM	Pain Management			NP PdP	Neuropathology Pediatric Pathology
CRS	Colon and Rectal Surgery					RIP	Radioisotopic Pathology
)	Dermatology	CLDI	Clinical and Laboratory Dermatological	Ped	Pediatrics	Al	Allergy and Immunology
_	Demiciogy	OLDI	Immunology			AM	Adolescent Medicine
		DI	Dermatological Immunology			CCM Cd	Pediatric Critical Care Medicine
		DP	Dermatopathology			CLI	Pediatric Cardiology Clinical and Laboratory Immunolog
ΞM	Emergency Medicine		MT Medical Toxicology			DLI	Diagnostic Laboratory Immunology
	g,	PEM	Pediatric Emergency Medicine			En	Pediatric Endocrinology
		SM	Sports Medicine			Ge	Pediatric Gastroenterology
		_				HO	Pediatric Hematology-Oncology
=P	Family Practice	Ger	Geriatric Medicine			Inf MT	Pediatric Infectious Disease Medical Toxicology
		SM	Sports Medicine			Ne	Pediatric Nephrology
М	Internal Medicine	Al	Allergy and Immunology			NP	Neonatal-Perinatal Medicine
		AM	Adolescent Medicine			PEM	Pediatric Emergency Medicine
		CE	Cardiac Electrophysiology			Pul	Pediatric Pulmonology
		CCEP	Clinical Cardiac Electrophysiology			Rhu	Pediatric Rheumatology Sports Medicine
		CCM	Critical Care Medicine			SM	Sports Medicine
		CLI CV	Clinical and Laboratory Immunology Cardiovascular Disease	PMR	Physical Medicine and Rehabilit	ation	
		DLI EDM	Diagnostic Laboratory Immunology Endocrinology, Diabetes and Metabolism	PS	Plastic Surgery	HS	Hand Surgery
		En Ge	Endocrinology Gastroenterology	PrM AM	Aerospace Medicine	MT	Medical Toxicology
		Ger Hem	Geriatric Medicine Hematology	PrM GPM	General Preventive Medicine	UM	Undersea Medicine
		Inf Nep	Infectious Disease Nephrology	PrM OM	Occupational Medicine		
		Onc Pul	Medical Oncology Pulmonary Disease	PrM PH PrMPHGPM	Public Health Public Health and General Prevent	antiva Mad	iaina
		Rhu	Rheumatology				
MCCDCC*	Clinical Disabamical Canatias	SM	Sports Medicine	ChiN	Neurology with Special Qualifications in Child Neurology	AdP ChAP	Addiction Psychiatry Child and Adolescent Psychiatry
	Clinical Biochemical Genetics	anation		N	Neurology	ChiN	Child Neurology
	Clinical Biochemical Molecular Go Clinical Cytogenetics	eneucs		Psyc	Psychiatry	C/Nph	Clinical Neurophysiology
	Clinical Genetics (M.D.)					FPsy Ger	Forensic Psychiatry Geriatric Psychiatry
MGCMGn	Clinical Molecular Genetics			Dad DD	Diamentia Dadialami	ND	Nuclear Dadiolanu
NCDPANO	Medical Genetics			Rad DR Rad DRnt	Diagnostic Radiology Diagnostic Roentgenology	NR PR	Nuclear Radiology Pediatric Radiology
vigetiniklig	Medical Genetics			Rad NM	Nuclear Medicine	VIR	Vascular and Interventional Radiolo
NS	Neurological Surgery			Rad R	Radiology		
	(NS-F indicates foreign certificate)		Rad Rnt	Roentgenology		
J. M	Nuclear Madining			Rad RO	Radiation Oncology		
NuM	Nuclear Medicine			Rad RT Rad TR	Radium Therapy Therapeutic Radiology		
ObG	Obstetrics and Gynecology	ССМ	Critical Care Medicine	Rad DRMNP	Diagnostic Radiology and Medic	cal Nuclea	r Physics
	,	GO	Gynecologic Oncology	Rad DRP	Diagnostic Radiological Physics		•
		MF	Maternal and Fetal Medicine	Rad MNP	Medical Nuclear Physics		
		RE	Reproductive Endocrinology	Rad RP	Radiological Physics		
Oph	Ophthalmology			Rad RRP	Roentgen Ray Physics Therapeutic and Diagnostic Rad	liological F	Physics
	. 0,			Rad TDRP Rad TRNP	Therapeutic and Diagnostic Rad	•	•
OrS	Orthopedic Surgery	HS	Hand Surgery	Rad TRP Rad XRP	Therapeutic Radiological Physic X-Ray and Radium Physics		•
TMC	Osteopathic Manipulative Therapy	,					
Oto	Otolaryngology			S	Surgery	GVS HS	General Vascular Surgery Hand Surgery
Path AP/CP	Anatomic and Clinical Pathology	BB	Blood Banking			PdS SCC	Pediatric Surgery Surgical Critical Care
Path AP	Anatomic Pathology	BBTM	Blood Banking Transfusion Medicine	TS	Thoracic Surgery		-
Path CP	Clinical Pathology	ChemP	Chemical Pathology	U	Urology		
		CytoP	Cytopathology	"	Urology		
		DP	Dermatopathology				

APPLICATION CHECKLIST

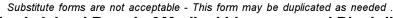
Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

<u>Board</u>	App	<u>olicati</u>	on

I have read and understand the "Instructions for Completing the Board Application."
I have completed the Rhode Island Board application as instructed (pages 6-12).
I have completed Section 20, "Affidavit of Applicant" and had the form notarized by a notary public.
I have attached a photograph to Section 21, "Recent Photograph" as instructed. I have verified that it meets the photograph requirements as stated in the application.
I have a check or money order made payable (in U.S. funds only) to the General Treasurer, State of Rhode Island in the amount of \$437.50 (or \$537.50 with CSR application) and attached the payment as instructed.
I have arranged my Board Application materials in following order:
 Fee (attached as instructed). Board Application (cover page, and pages 6-12) Supporting documentation as required. [Note: Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.
4. RI Uniform Controlled Substances Registration (CSR) (page 19) (If Applicable).
I have mailed the above application materials directly to the Licensing Office, Department of Health.
Required Forms / Letters
I have completed and mailed the following forms as instructed:
 Reciprocity Release Form(s) (Licensure Verification) Practitioner Request for Information Disclosure (National Practitioner Data Bank) Four (4) Reference Forms
FCVS Application
I have completed the FCVS application, and submitted all required forms, documents, and fee directly to FCVS.

Note: In order to dispense, prescribe, store, or order controlled substances, you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.

The Rhode Island CSR Application is available on page 19. After you obtain your Rhode Island CSR you can apply | for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA: □
DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/





Rhode Island Board of Medical Licensure and Discipline

Room 205, Three Capitol Hill Providence, RI 02908-5097 (401) 222-3855

RECIPROCITY RELEASE FORM

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address. Print/Type Full Name Signature Date Previous Names Used Social Security Number Date of Birth License Number Date Issued THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD Basis for Issuing License: ☐ FLEX _____ (State Sponsor) □ NBME ☐ NBOME ☐ USMLE ☐ LMCC ☐ State Exam _____ (State) If a combination of exams were taken, please list the specific combination: License Status: Original Date Issued: **Expiration Date:** ☐ Active ☐ Inactive ☐ Lapsed Questions: 1. Has this physician ever been investigated by your Board? Yes □ No 2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes □ No 3. Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended, revoked or placed

Yes ☐ No on probation? 4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank? ☐ Yes □ No 5. Do you know of any information that may discredit this person? ☐ Yes □ No If you answer "Yes" to questions 1-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.). **Certification:** Date Signature Type or Print Name Please Affix **Board Seal Here** Title Full Name of Licensing Board Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Substitute forms are not acceptable - This form may be duplicated as needed .



Rhode Island Board of Medical Licensure and Discipline

Room 205, Three Capitol Hill Providence, RI 02908-5097 (401) 222-3855

REFERENCE FORM

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires this reference form to be completed as part of my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Applicant Should Complete this Section Only	:						
Print/Type Full Name	Signature				Date		
Social Security Number	Date of						
Based upon demonstr		ALUATION and composite of	f evaluations by	supervisors on	file.		
		Superior	Good	Fair	Poor	No Info.	
Basic Clinical Knowledge							
Professional Judgement							
Clinical Competence and Skill							
Reliability/Sense of Responsibility							
Patient Management							
Ethical Conduct							
Physician-Patient Relationship							
Ability to Work with Other Hospital Staff							
Appearance							
Medical Recordkeeping							
Ability to Communicate Verbally							
	Overall Rating:						
Recommendation:	ļ.						
☐ Recommended Highly without Reservation	□ Recommend	ded as Qualified	and Competent	□ п	ecommended w	ith Reservation	
☐ No Comment						iii reecivation	
- No comment	□ Not Neconii	nenaca					
Additional Comment (use reverse side if nece	ssary):						
You must affix your institution's official	seal or have you	ur signature	notarized.		·······		
Printed Name of Reference	Signature				· · · Please · Hospit		
Title	Date	Date			Notarial Seal Here		
Relationship to Applicant Please return directly to to	he Board at the abov	ve address. Tha	ank you for your	prompt cooper	ation.		

IF Applying for CSR, this Application **MUST** BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION.

Substitute forms are not acceptable



Rhode Island Board of Medical Licensure & Discipline

Room 205, 3 Capitol Hill Providence, RI 02908-5097 (401) 222-3855

Rhode Island Uniform Controlled Substances Act Registration (CSR)

rint/Type Full Name		Business Na	me				
Signature		Business Ad	dress	Business T	Business Telephone		
Date				Business	Fax		
Complete this application for			Act can be accessed at the /Statutes/Title21/21-28/ind		Site:		
registration to prescribe controlled	Drug Schedule (Check all that apply)						
substances in the State of Rhode Island	Schedule II	☐ Schedule III	☐ Schedule IV	Sche	eduleV		
A CSR is not required if there will be no controlled substances prescriptions	A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*						
prescribed in this state.	All Applicants MUST ans	wer the following:					
The CSR is renewed at the same time that the professional license is renewed.	A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island?						
NOTE: Read Important Information on the bottom of this application.	B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending?						
	If you answered	d "Yes" to question "A" o	or "B" attach an explanatio	on to this form.			
Issuance of a Rhode Island	Controlled Substances Registration	Important Information is contingent upon registration	ation by the U.S. Drug Enforcement Ad	ministration. If denie	ed a "DEA Registra-		
tion", the Rhode Island Cont dispense, possess, store or Substances Registration (Cs controlled substances within	trolled Substances Registration be ship controlled substances in or in SR), and a federal Drug Enforcem their particular "scope of practice Rhode Island Uniform Controlled S	comes "VOID". Licensed drug fato the State of Rhode Island with lent Administration (DEA) Regist ". "Controlled Substances" for pure standard controlled Substances."	acilities and licensed practitioners we hout a valid drug facility or professitation. Practitioners may only presurposes of this application, means a of the Federal Code of Regulation.	vith prescriptive privil ional license. Rhode cribe, dispense, poss a prescription drug in	e Island Controlled sess, and store Schedules II		

Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

State of Rhode Island and Providence Plantations



DEPARTMENT OF HEALTH

Office of the Director
Cannon Building
3 Capitol Hill
Providence, RI 02908-5097

Mandatory Addendum to License Application

Verification of Social Security Number/Federal Employer Identification Number and affidavit concerning taxpayer status

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Signature	Date	Social Security Number (SSN) or Federal Employer Identification Number (FEIN)

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.

This form <u>MUST</u> be completed, signed and attached to your license application in order for us to process your application.